A Consumer's Guide to Financing Long-Term Care

Insurance and Other Options

A guide to making your best choices

about long-term care options and ways to finance them

Published by the Office of Washington State Insurance Commissioner Mike Kreidler

A message from the Insurance Commissioner

Medicare does not cover long-term care; Medicare supplements do not cover long term care; and managed care plans do not cover long term care. Employer plans cover little if any long-term care.

Therefore, it is a good idea to give some thought to your potential long-term care needs and how you might pay for them.

This Guide will help you learn about and understand important long-term care issues, including:

- types of long-term care services, providers and delivery systems
- how to assess your risks and plan accordingly
- options for paying for long-term care
- where to go for more information

The Office of the Insurance Commissioner publishes other health insurance guides to educate and assist consumers. A list of these and additional resources is printed on the inside back cover of this publication.

Also, please take full advantage of the expertise our Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine volunteers can offer you. Their advice is *free* and completely objective. No SHIBA HelpLine volunteer has any affiliation with any insurance company or product.

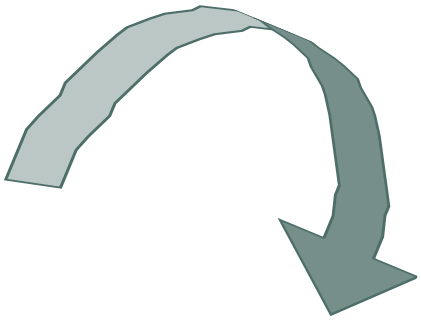
SHIBA HelpLine serves *all* of Washington state, including people who need to make decisions about individual insurance, government programs (Medicare, Medicaid, Basic Health, Washington State Health Insurance Pool), Medigap (supplementing Medicare benefits obtained at age 65 or through disability), employment-related benefits, managed care, long-term care, medical billings, and more.

Dial toll-free: 1-800-397-4422 for the number of the SHIBA HelpLine office nearest you. Or visit www.insurance.wa.gov or www.insurance.wa.gov/shibahelpline.htm.

with questions, comments, complaints about other insurance (auto, life , homeowners, disability, ETC.)
CALL:

INSURANCE COMMISSIONER'S TOLL-FREE CONSUMER HOT LINE
1 (800) 562-6900

Table of Contents



Long-Term Care: The Other Retirement Planning

What is long-term care?

Long-term care (LTC) is a general term covering a wide range of services. These services address the health, medical, personal care, and social needs of people with chronic or prolonged illnesses, disabilities, and cognitive disorders (such as Alzheimer's). These services are most typically required by the elderly, but may also be used by disabled people of any age.

In the past, long-term care was thought of as strictly nursing home care. But today the term may refer to any of a variety of private and semi-private care situations and services: home health care, assisted living, adult day care, adult family homes, continuing care retirement communities (CCRCs), rehabilitation therapy, and more.

Services that help people live outside of a nursing home, often in their own home, have become increasingly common and desirable. Keeping people as independent as possible has become the preferred goal of long-term care.

LTC services called *respite care* give relief to those who provide informal care, such as spouses, other relatives and friends.

Who needs long-term care?

For some people, the need for long-term care arises due to a chronic or terminal illness, or general disability. It may also come from frailty that renders the individual incapable of performing activities of daily living without assistance (such as bathing alone).

For others, the need for care may be shorter-term. Injuries and acute conditions—even short stays in the hospital—can leave people temporarily needing care they cannot provide themselves.

It's impossible to be absolutely certain who will need LTC. But there are risk factors that help us make educated guesses. These factors are discussed on pages 6-7 and page 12 of this Guide.

The U.S. Senate Subcommittee on Aging says that the number of older people needing long-term care is expected to jump from 7 million in 1990 to 12 million in 2040.

Other projections suggest that nearly half of all Americans over 65 can be expected to eventually spend some time in a nursing home or need some other type of long-term care. For people over age 85, this number increases to 60 percent.

Types of long-term care

The type of long-term care required depends on the individual's condition. Types of long-term care can be divided into two broad categories: long-term *health care* and *personal care* (which used to be called *custodial care,* now an obsolete term).

Personal care is physical assistance, prompting, and/or supervising the performance of personal care and household tasks, for people unable to do so alone. This includes help with what are known as "Activities of Daily Living" (ADLs)—eating, dressing, taking medicine, bathing, toileting, transferring and continence. These are *not* medical/health services.

Long-term health care is medical care given by licensed health care providers.

Either type of care may be given in a *nursing facility.* If medical care is given at home, it may be called *home health care.* Personal care given at home may be called *"home care."*

Types of care providers

Since there are many types of long-term care situations, there are many different types of providers. Some are traditional and established; others are newer, unique and innovative.

Current types and providers of long-term care include, but are not limited to:

- nursing homes
- assisted living facilities
- adult residential care centers
- home health agencies
- adult family homes
- hospital sub-acute units
- respite care
- Alzheimer's units
- chore workers
- social workers
- family caregivers
- life care communities
- hospice centers
- adult day health care
- continuing care retirement communities

Long term care may also involve other professional services. These may be adjunct services used in one of the care situations listed above, or they may be stand-alone services:

- nutritional counseling
- speech therapy
- physical therapy
- occupational rehabilitation
- meal services
- transportation
- case management
- lab services

Other services include structural changes to a home including ramps, guard rails, and others that might enable a person to remain independent at home.

What does LTC cost?

Long-term care other than that provided by family members can be very costly, especially if the duration is long. Cost depends on who provides care, where, and for how long.

In Washington state, private assisted living facilities and adult day care can run about $75 per day. In-home personal care services average between $30 and $70 dollars per day.

In 1997, the national average cost for private nursing home care was $40,000 to $50,000 a year and reached as high as $75,000 a year. The cost of nursing home care is increasing by five to 10 percent per year.

It is important to consider the issue of how these costs would be covered, should they arise.

The planning process: getting started

The purpose of this guide and of SHIBA counseling is to help you make educated decisions (without pressure to buy something you may not need or want) and to encourage you to consider an area of long-term financial planning that is crucial but that is often not considered.

It's a good idea to include planning for long-term care as part of long-term financial/ life planning.

People become aware of the need for long-term care and coverage for this possibility at different times. You may be interested because of family health issues that are currently arising, financial issues, or other events.

You may also be in the position of dealing with LTC services or insurance (either potential or in-force) for a spouse, parent, or other family member.

Addressing future (possible) long-term care needs

When planning for the future, your choices will mainly be determined by *preferences*—lifestyle, social, familial, and others—rather than by pressing medical requirements or needs. Consider:

- the relative likelihood of your need for long-term care,
- the kind of care situation you'd prefer, if you needed it,
- the best way to pay for it, should the need in fact arise.

Preparing for the possibility of long-term care means different things for different people, but >>>

Note:

There is a distinction between long-term *care* (the services and care itself), and long-term care *insurance* (or other coverage methods).

What kind of *care* is desired (and/or likely to be needed) must be considered as well as how to cover possible future *costs*. The cost of your preferred option (for example, an adult family home) may determine how much coverage, and what kind, you will need. If purchasing insurance, you will need to know that the favored option(s) are covered by the policy.

ultimately it comes down to protection of one or more of these three things:

- money/assets (for yourself or heirs);
- family/loved ones;
- one's lifestyle/independence/dignity.

The planning questions in the box below only offer subjective answers, but they do a lot to help you realize what you may or may not need, or what you will or will not be able to tolerate. This can help rule out certain options, or clearly underscore the importance of others. *They also provide a basis for dialogue,* which is vital to the process.

Sometimes this subject is difficult to talk about, but everyone is better off when some thought has gone into how these issues will be handled should they arise.

It is wise to discuss long-term care issues with children and/or spouse, and to see a SHIBA counselor to assist with your planning and get your questions answered.

The rest of this guide will assist you in making the assessments and evaluations listed below.

Once you have a sense of your likelihood of needing long-term care, your preferred care scenario(s), and how much it will cost, you can look at ways to plan for those costs.

Helpful planning questions and steps

1. WHAT IS MY RISK? *Assess future likelihood of needing long-term care.*

- Are you are a high-risk candidate for disease, disability, or injury (based on lifestyle, health habits, health history, and family health history)?
- Is there a history of longevity in your family?

2. WHAT ARE MY OPTIONS? *Understand and consider different types of care*

- Learn about the range of options for receiving care
- Choose the care setting(s)—nursing home, home care, adult family home, adult day care, etc.—that would be reasonable or practical if you needed care
- Consider potential support network; family's needs and wishes; and level of independence you desire

3. HOW WILL I PAY? Plan how you will *pay for* desired options if needed.

- Consider your financial assets, income, and age
- Consider whether or not insurance is appropriate, financially and based on your risk level
- Consider specific long-term care policies, if insurance is appropriate
- Learn about alternatives to insurance as payments for long-term care (self-pay, investments, etc.)
- Evaluate an insurance choice or other plan you have already made, if necessary

Write down your answers (use additional sheet of paper if necessary), then discuss with family, elder law attorney and/or estate planner. There are no easy "scores" to tally that will tell you what to do about long-term care, and some of these questions are hypothetical. However, the answers can help you, and help others assist you, in making informed decisions.

How is long-term care paid for?

Payment methods for LTC

Ways to pay for long-term care can include:

- *Limited* Medicare (only *extremely limited* nursing home coverage on—ironically—a short-term basis; see pages 8-10)
- Long-term care insurance (either *conventional*; a special type of long-term care policy called a *Partnership* policy; or a policy *qualified* for special tax treatment)
- Medicaid (state-sponsored health care for impoverished residents; recipients must meet income limits annually, and may initially have to "spend down" assets to established limits)
- Self-funding (which means paying for care with your own funds—"out-of-pocket"—with personal or family money, pensions, benefits, savings or investments. This may include the use of special investments such as accelerated life insurance benefits, reverse mortgages, or trusts—alternatives we will discuss later)
- *Limited* Veterans' Administration funds (may provide long-term care for *service-related* disability, or for a limited number of eligible veterans and/or their spouses)

The best way for an individual to pay for long-term care will vary from person to person.

To determine the best LTC payment/coverage method, you should understand the basics of each method and its pros and cons.

In the sections that follow, we will detail how each method works, its potential benefits,and its disadvantages and limitations.

1. Medicare: *The LTC Myth*

Despite a persistent myth to the contrary, *hardly any long-term care costs—about 2 percent*—are covered by Medicare, Medigap policies, managed care, or any other regular health insurance.

Medicare will pay for a *limited* stay in a nursing home *under specific conditions.*

Medicare Part A will help pay for care in a Medicare-approved nursing facility when the patient meets ALL of the following conditions:

☑ Patient is admitted to a hospital for at least 3 consecutive days (not counting day of discharge).

☑ The physician certifies that the patient needs *skilled* nursing or rehabilitative services on a daily basis.

☑ The patient goes to a Medicare-participating facility for *skilled* care within 30 days after release from the hospital, for the same condition (or a related condition) for which he was hospitalized, and receives the skilled nursing or rehabilitative services on a daily basis.

The patient is in a Medicare-designated bed in a Medicare-approved nursing facility.

As long as ALL of these conditions are satisfied, Medicare will help pay for a maximum of 100 days in each benefit period. (How much Medicare will pay changes annually; check with DSHS or a SHIBA volunteer for current figures.)

These conditions must be satisfied for each new benefit period. However, if a patient leaves a nursing facility and is re-admitted within 60 days—for further daily treatment of the condition(s) treated during the last stay at the facility—he does not need a new three-day hospital stay for care to be covered. The patient is considered to still be in the same benefit period.

Medicare pays only for limited skilled health care

Earlier we discussed the differences between health care and personal care, and the differences between home health care and home care (see page 5). The majority of people who need long-term care actually require personal care (as defined on page 5), but that type of care is *rarely* covered by Medicare.

Medicare covers only skilled health/professional care. It does not cover personal care in a nursing home, and it covers only small amounts of personal care at home under stringent conditions.

What is skilled health care?

Generally, skilled care refers to medical care provided under the supervision of licensed medical personnel.

Medicare considers rehabilitative services such as occupational, physical or speech therapy to be skilled care if they are needed on a daily basis, ordered by a physician, and provided by skilled (technical or professional) personnel.

In some special cases, a *service* that is generally considered nonskilled may be considered as a skilled service if, because of special medical complications, its performance or supervision *necessitates* the use of *skilled personnel,* and this is documented by a physician's orders.

Medicare pays based on the type of care—not the type of facility

All nursing facilities in Washington state must provide all levels of care—personal care *as well as* health/medical care. Thus it is possible to receive *only* personal care at a nursing facility.

Medicare will *not* pay for a stay in a nursing facility if the care being provided is mainly personal care. A nursing facility is *equipped* to provide medical care under the supervision of licensed nursing personnel—but the fact that such care is available there doesn't mean it is required or being provided.

Retirement facilities and assisted living facilities which do not provide any skilled care at all are not "nursing facilities," and they are not covered by Medicare at all.

Will Medicare cover care at home?

Medicare will cover home *health* care—*skilled nursing care in the home*—from a Medicare-approved agency, if a physician certifies that the patient is confined to the home and needs skilled nursing care or rehabilitative therapy at least once every 60 days. >

A plan of care must be established and reviewed at least every 62 days by a physician.

There is no limitation on the number of home health visits. Home health benefits can be paid with or without a three-day-hospital stay. Per the Balanced Budget Act of 1997, as of January 1, 1998, Medicare Part A will continue to cover the first 100 home health visits following a three-day hospital stay or a nursing facility stay. Otherwise, Part B will cover the care.

NOTE: there IS a three-day hospital stay requirement for Medicare to pay for a nursing facility stay.

Part-time and temporary care

If the patient qualifies for home health services, Medicare will cover the home health services on either a part-time or temporary basis.

Part-time means up to and including 28 hours per week for less than eight hours per day. (Additional time up to 35 hours per week may be approved by Medicare on a case-by-case basis.)

Intermittent care is subject to the same weekly limit of hours, but is usually not provided on a daily basis. Intermittent care can also mean up to and including eight hours per day of daily care on a temporary period of up to 21 days. (Again, in exceptional circumstances, extensions are occasionally approved by Medicare on a case-by-case basis.)

What about hospice care?

Hospice is a special way of caring for an incurably ill patient whose life expectancy is six months or less if the disease runs its normal course (often at the end of a long-term illness).

Hospice patients receive a full scope of medical and support services, not aimed at curing and counteracting the disease but rather to make the dying patient comfortable in his or her last months. Hospice also provides family support.

While not conventionally considered a long-term care service, hospice may be appropriate at the end of a period of long-term care, when death is imminent. It may replace or complement other LTC services at that time.

Medicare coverage of hospice

Medicare beneficiaries certified by a physician as terminally ill may elect to receive hospice care from a *limited* network of Medicare-approved hospice programs, either at home or in a nursing facility.

Once hospice care has been elected, Medicare beneficiaries cannot use Medicare benefits to cover treatment of conditions related to the terminal illness. (Standard Medicare coverage may be used for treatment of conditions unrelated to the terminal illness.)

Medicare has special benefit periods for beneficiaries who enroll in a hospice program. Medicare's hospice benefit period includes two 90-day periods, followed by an unlimited number of 60-day periods.

The medical director or a physician member of the hospice interdisciplinary team must re-certify that the beneficiary is terminally ill at the beginning of each new 60-day period.

NOTE: not all areas of the state have hospice programs, and not all hospice programs are Medicare-certified.

2. Insurance: *Long-Term Care Policies*

To explore if insurance is the best option for you (or for a family member), you must understand two things:

- ☑ how LTC insurance works in general
- ☑ how policies differ specifically

Then you can decide which type of policy will offer the best and most appropriate protection at the most affordable price.

What is long-term care insurance?

Long-term care insurance may consist of an individual insurance policy, or group coverage including a master policy and certificates of insurance. These policies will pay benefits for a specified range of long-care services when an eligible claim is made.

What does private long-term care insurance cover?

Like most insurance policies, what services are covered and when benefits are paid will vary from policy to policy. However, there are minimum standards for all LTC policies sold in Washington state, and rules and regulations written and enforced by the Office of the Insurance Commissioner.

The services addressed by LTC insurance include nursing home care, home health care (medical care administered in the person's home by a qualified professional), home care and community-based care. Community-based care encompasses many alternative options such as assisted living, adult day care, adult family homes, continuing care retirement communities, and hospice care.

All long-term care policies sold in Washington state must cover all levels of care in a nursing home, whether personal or skilled care. They also must cover care for mental and emotional illness—including Alzheimer's disease and senility—as well as for physical conditions.

Other long-term care benefits do vary widely by policy. For example, some policies may:

- pay a fixed benefit amount per day.
- have daily limits on payouts.
- have a ceiling on total benefits.
- exclude benefits for some services.
- impose elimination (deductible) periods—designated time periods before benefits begin.
- impose other conditions before policy begins to pay, such as type of care or provider.
- cover alternatives such as assisted living, adult day care or home health care (or others agreed upon by patient, doctor, and insurer).
- allow you to stop paying premiums once you are receiving care paid for by your policy.
- offer an option to ensure that coverage keeps pace to some extent with the rate of inflation.
- after some benefits are used, offer restoration of benefits when a certain amount of time passes with no care.
- impose conditions such as length of stay in a facility or length of time receiving care before you can stop paying premiums.

These are only a few of the possible variations in benefits or limitations. There are minimum standards or standard definitions for some of these features. These and other common policy features are detailed later in this guide. This guide also includes assessment forms to help you determine which features a policy includes, and to compare policies. Consult a SHIBA HelpLine volunteer (800-397-4422) for help with policy assessment and comparison.

Understanding pros and cons

There are benefits and costs to insurance, even for good candidates. The right insurance can protect you against the financial and practical burdens of long-term care in the event that it is required. The cost of a policy can be minor compared with potential out-of-pocket costs.

Yet there exists the possibility that you will never need long-term care, that very little of the policy's benefits will be used, or that care won't actually trigger policy benefits. It is possible to end up paying more for insurance than you would have in out-of-pocket expenses.

The auto insurance analogy

In the case of auto insurance, for example, we pay for a variety of coverage options that will pay auto repair or replacement costs, and sometimes injury protection for ourselves and others, in the event of an accident.

Some people never get in any auto accidents, and thus never recoup auto insurance premiums. But the insurance is worth the money for the peace of mind.

For others, just a single accident can make all those premiums worthwhile, as their insurance covers possibly astronomical costs they would have otherwise paid out of pocket.

Long-term care insurance does not work exactly like auto insurance. But there are some general similarities: you may never use the coverage, but it can provide peace of mind "just in case." If you do use it, the investment can pay off significantly.

Factoring in risk

Some drivers statistically are more at risk than others for becoming involved in an auto accident. Likewise, some people are more likely to need long-term care (and thus possibly insurance or other coverage). There are no guarantees, but the presence of certain factors may suggest a greater likelihood of needing care.

Again using the auto analogy, factors known to increase risk for being involved in an auto accident include age, marital status, type of car, driving record, and miles driven annually. Higher-risk people are often encouraged to have more insurance coverage (e.g., lower deductibles, optional insurance such as collision coverage).

Likewise, factors known to increase risk of disabling disease (which can in turn boost risk of needing care) include age, current health status, health history, family health history, and habits or conditions such as smoking, excessive alcohol consumption, or obesity. A family history of longevity is another factor (after age 65, the statistical likelihood for needing long-term care increases exponentially with every decade).

Factors suggesting an increased need for *insurance* include a high risk for needing *care*, lack of resources to pay for care; a surplus of resources you'd rather preserve than exhaust; sufficient income to pay long-term care premiums; and/or lack of support network for receiving care from family or friends.

Many of these issues can be assessed using the steps on page 7, as well as the checklists on page 13. You may wish to discuss your answers to these questions with a SHIBA HelpLine volunteer, who is trained to help you evaluate your needs and options. **See inside back cover for more on SHIBA HelpLine.**

Tip:

A good candidate for a long-term care policy will usually (though not always) save money by buying the policy sooner rather than later. Premiums are based on age at the time of purchase, and will probably increase each year you wait to purchase, regardless of health status.

Is LTC insurance right for you?

Who is a good candidate for a long-term care policy?

A long-term care insurance policy *may* be right for a person who:

- has assets he would like to protect or leave to others, or that have sentimental value
- is able to afford monthly premiums
- would be unable (or is unwilling) to pay out-of-pocket for a long duration of long-term care if the need arose
- is not currently disabled or seriously ill, but has a family history of longevity, or a health history and/or lifestyle suggesting increased risk for disabling disease or injury
- wants to ensure independence and control over his money and assets
- wants to protect his family members and their lifestyle from the burdens of providing long-term care
- has an income level too high to qualify for Medicaid

Who is not the best candidate for a LTC policy?

A long-term care insurance policy may *not* be right for a person who:

- has few or no assets to protect (less than the cost of one year in a nursing home, about $40,000, is one rule of thumb that may be used)
- is unable to afford insurance premiums, either now or in the future
- is already disabled or has a serious health problem (and might not pass the medical underwriting required to get coverage—however, it may be worthwhile to try)
- has an income level that meets Medicaid eligibility limits
- has enough assets to be self-insured and chooses that option
- has no surviving loved ones or favorite causes to whom to leave assets

Note:

Long-term care insurance is an ongoing commitment. You must be able to continue to pay the premium for many years—not just now—until you may need LTC. If you buy a policy and later stop paying premiums, you lose policy benefits and the money spent on past premiums (unless the policy has a *nonforfeiture* feature—see page 24).

If you do not plan to purchase a long-term care insurance policy, it is highly advisable that you have in mind—and in place—some other strategy for paying for LTC should the need arise.

Other methods for funding LTC are listed on the next few pages (numbers 3 and 4 following).

3. Self-Pay: *Personal Money*

Self-pay for long-term care involves use of personal or family money to pay for care should the need arise. This can include savings, investments, assets, pensions, benefits, and/or contributions from children or other relatives, as well as reverse mortgages, annuities, and trusts.

Generally, self-pay is possible only for individuals with above-average wealth and/or an extraordinary commitment from the family to assist with care. Individuals whose disposable income exceeds the cost of care are the best candidates for self-pay, since they have the luxury of taking the chance on never needing care.

Such plans are best made with the advice of an Elder Law attorney (familiar with Medicaid eligibility and estate planning) and perhaps an estate planner.

Medicaid issues and self-pay

Because self-pay for LTC can result in exhaustion of all assets, eventually leading to Medicaid eligibility—and because some people actually expect this to happen and plan to transfer (or give away) assets in order to qualify for Medicaid—it is impossible to completely separate a discussion of self-pay from the discussion of Medicaid.

Medicaid is a medical assistance program that is jointly funded by state and federal government. It is administered by state government (the Washington State Department of Social and Health Services, [DSHS]) with federal assistance from the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (DHHS).

Medicaid assistance, including for long-term care, is available only to people whose income and assets are below certain levels.

Medicaid is an extremely intricate and complex subject with many possible variables and many legal and financial ramifications.

Medicaid is not insurance; it is government-funded assistance (technically, what some people call "welfare"). The Office of the Insurance Commissioner does not administer or regulate Medicaid.

Resources on Medicaid

☑ To learn about current conditions for Medicaid eligibility, contact the local Department of Social and Health Services office or Senior Information and Assistance office (National Locator number is 800-677-1116).

☑ You can also consult an Elder Law attorney who specializes in Medicaid eligibility and estate planning issues.

Note:

Consumers should be aware of potential conflicts of interest when seeking advice from experts (such as estate planners, tax attorneys, life insurance agents, etc.) on any long-term care self-pay/investment options.

Reverse mortgages and annuities

With a "forward" mortgage, the kind of loan most people have on homes, payments are made on a loan balance that compounds interest. This balance is reduced by our payments (usually in monthly installments over a period of years), until it is finally paid off.

A reverse mortgage, true to its name, reverses that process. It is a loan against a home's equity (net worth—market value minus what is owed on it) in which there are no payments required, so the principal balance actually increases. (Interest is added to the principal loan each month.) The balance, however, is guaranteed never to exceed the net value of the home.

This enables the "house rich, cash poor" older homeowner to utilize the home's equity, turning it into spendable cash with no monthly payments, while owning and living in the home. The borrower retains ownership of the home, as with any other mortgage, and remains responsible for taxes, repairs and maintenance.

When the borrower no longer occupies the home—whether because he moves, sells, or dies—the loan must be paid off as would any other mortgage. The loan is then due with interest and loan fees. It is paid off by the proceeds of the sale, or through refinancing as a regular (forward) mortgage by heirs.

The cash generated by the reverse mortgage is not taxable income. It does not affect Social Security, Medicare benefits, or Medicaid benefits.

Interest on a reverse mortgage is not deductible for income tax purposes until the loan is paid off.

The money may be used for any purpose the borrower wants, including long-term care or the spouse of an individual who is on Medicaid.

Loan fees reduce the amount of cash available; fees are not due until the loan is paid back (they are financed—added to the total loan amount). The funds can be drawn out in lump sum, monthly advances, or a line of credit.

Reverse mortgages are usually adjustable rate mortgages, or ARMs. Interest accrues according to an interest rate that adjusts annually, within a limited margin. These changes are tied to an independent index not controlled by the lender (usually based on a national measure like the prime rate).

To be eligible for a reverse mortgage, the younger borrower must be 62 years of age or older, the home must be owner-occupied, and there must be accessible equity in the property. The borrower does not need to have any income to qualify, but must own the home free and clear, or close to it. Specific loans may have other requirements.

With few exceptions, the borrowers also must undergo a consumer education session with an approved agency not affiliated with the lender.

Disadvantages of reverse mortgages

If you do not reserve some of the equity in your home, you could be left with little or no money after you pay off the loan balance. If you use up all the equity, and repayment occurs at death, there will be little or no money left for heirs. If repayment occurs because you move, or go into a nursing home or alternative living situation, there will be no cash equity left over for you. Even if you do not tap all of the equity in your home, you will still have fewer assets to leave your heirs in the future.

For more information about reverse mortgages, the following detailed publications are available:

☑ HOME-MADE MONEY: Consumer's Guide to Home Equity Conversion
(AARP: Stock #D12894, AARP Home Equity Information Center, 601 E. Street N.W., Washington, D.C., 20049. 202-434-2277)

☑ REVERSE MORTGAGE LENDER'S LIST: State-Specific
(AARP: Stock #D13253, AARP Home Equity Information Center, 601 E. Street N.W., Washington, D.C., 20049. 202-434-2277)

☑ REVERSE MORTGAGES: FACTS FOR CONSUMERS
(Federal Trade Commission, Bureau of Consumer Protection 202-326-3650

Accelerated Death Benefits

Accelerated death benefits in a life insurance policy may be used to obtain cash out of the policy while the policyholder is still alive. Under an accelerated death benefit option, the insured and the insurance company agree that if the insured later meets specific medical conditions relating to imminent death, the insured may elect to have either a percentage of the death benefit or the whole benefit paid out ("accelerated") during the lifetime.

Several different types of distribution for accelerated payments are legally allowed. The distribution method and any fees involved would be specified in the policy.

There are also restrictions regarding who can qualify for an accelerated payout (based on medical diagnosis of life expectancy) and how much money may be advanced.

In all types of accelerated benefit payments:

- The policyholder still owns the policy and must continue to pay premiums (which are lower than before, since the face value of the policy is reduced).
- Whatever value remains in the policy is still paid to the beneficiary at the time of the policyholder's death.

Both cash value and term policies may be written with an accelerated death benefit provision.

Usually, evidence must be submitted showing that the reasonable medical certainty of life expectancy for an incurable terminal illness will result in death within a specified time period (no less than six months and no more than 24 months).

This time period may restrict the usefulness of accelerated death benefits for the purpose of long-term care (accelerated death benefits are more commonly used by terminally ill people). However, to pay for long-term care services at the end of an extended period of long-term care, or when it is unlikely that care will be needed for more than 24 months, this option may be useful.

Note:

Pre-death payment of a life insurance policy (whether from accelerated benefits or viaticals) is a step that should be undertaken with extreme caution. An estate planner should be consulted to consider the tax and financial implications of such a plan.

Many insurance companies will now allow an accelerated death benefit rider to be added to an existing policy. Whole life policies, which build up cash value, may have this benefit written into the policy.

CAUTION: If you are counting on life insurance to pay estate taxes or support your family, be sure to reserve enough policy benefits to meet your life insurance needs. If you accelerate benefits for long-term care purposes, you may be using money that is needed for other purposes.

Viatical Settlements

Viatical settlement providers are third-party settlement companies that purchase the rights of the insured in an existing policy, paying the policyholder a percentage (usually a fraction) of the full face value of the policy.

In a viatical settlement, the insured sells all rights in the policy to the viatical company. The payment to you is computed with reference to the face value of the policy and the insured's likely survival.

The insured typically retains no further ownership in the policy—the viatical company becomes the owner, paying the premiums and collecting the proceeds (the face amount of the policy) upon the death of the insured, thus recovering the initial investment and a substantial profit. The original beneficiary gets nothing.

Viatical settlements are often available on terms and under conditions that an accelerated death benefit would not be, such as a longer life expectancy.

Currently, there are about 50 companies nationwide that engage in viatical settlements, but only a few are licensed in Washington state.

Under Washington state regulations, viatical settlement firms and agents have to register with the Insurance Commissioner's office and comply with consumer-protective rules. Washington is one of only a handful of states that regulates these companies.

4. Miscellaneous Methods: *Other Ways to Pay*

Veterans Benefits

Veterans Benefits may provide long-term care for service-related disability, or for certain eligible veterans and/or their spouses. For more information, contact the Veteran's Administration.

If long-term care insurance is the right choice: Understanding, Analyzing, and Comparing Policies

In this section, you will learn how LTC policies work; definitions of features, requirements, and other important terms; and tools for analyzing policies.

How long-term care insurance works in Washington state

The Washington State Insurance Commissioner is responsible for regulating individual long-term care policies sold in Washington state, as well as some group LTC policies sold from outside the state to Washington state residents.

The long-term care industry has changed over the past decade. New rules have been established by the Insurance Commissioner in the last few years governing long-term care insurance, to make it more flexible and easier to understand and to buy.

Rules adopted by the Insurance Commissioner between 1988 and 1996 brought about some uniformity in policy standards and definitions. Thus there are some differences between older policies and new policies that you should be aware of.

Older LTC policies

From 1966 to 1985, long-term care insurance sold in Washington state was primarily for skilled nursing home care—"nursing home insurance"—with many limitations on benefits. The term "nursing home insurance" refers to most policies that were sold before January 1, 1988. These do not meet the standards defined in the new LTC insurance code, so they are not properly called long-term care policies.

Today, the majority of long-term care insurance policies include coverage for care received beyond nursing home care.

The Long-Term Care Partnership

A new law in June 1995 established the Washington State Long-Term Care Partnership (LTCP), modeled after a Connecticut pilot that has been implemented in a handful of other states. The law allows the sale of special long-term care insurance policies that offer unique asset protection. The person who buys a Partnership-approved policy becomes subject to special, more favorable rules for Medicaid eligibility. The Partnership policyholder will be able to keep or give away some or all of his assets and *still* qualify for Medicaid to pay for care (if all other qualifications for Medicaid eligibility were met.)

However, such policies have not been made available by insurers. If you buy a long-term care insurance policy now, you *may* have an opportunity to upgrade to a Partnership policy. Before purchasing a regular policy, ask whether or not you will have the opportunity to upgrade.

Contact a SHIBA HelpLine volunteer for the current status of the Long-Term Care Partnership in Washington state: 1-800-397-4422 for a referral to the SHIBA HelpLine volunteer counseler nearest you.

Features and requirements of LTC insurance policies

A long-term care insurance policy or contract will specify which kinds of services are covered, and by which type of provider, and under what circumstances.

It's important to familiarize yourself with current definitions, requirements and features involved in long-term care insurance policies. These include:

- basic policy types;
- basic elements of policies and how they work;
- key features and benefits; and
- requirements that must be satisfied before benefits can be paid.

Types of coverage

Nursing home coverage is coverage for confinement in a nursing home for any level of care.

Home health coverage is coverage for home health and/or home care (chore) services.

Comprehensive or integrated coverage offers benefits for nursing homes *and* home health, community-based and/or alternative care. The most effective policy of this type does not stipulate any sequence in which care must be given. (Policies that require a nursing home stay *before* home care will be covered are no longer legal to be sold in Washington state.)

Methods of calculating/ distributing payment

Actual Cost Up To Daily Maximum: This type of policy will pay less than the daily maximum if the actual cost is less. If the actual cost is higher than the daily maximum purchased, it will only pay the daily maximum.

Indemnity: This type pays the actual amount of benefit in the policy, regardless of the cost of services. For example, if a $100-a-day benefit was purchased, the policy will pay $100 even if actual cost is $75 or $125.

Coinsurance or percentage of cost: Pays a set percentage of the cost of services.

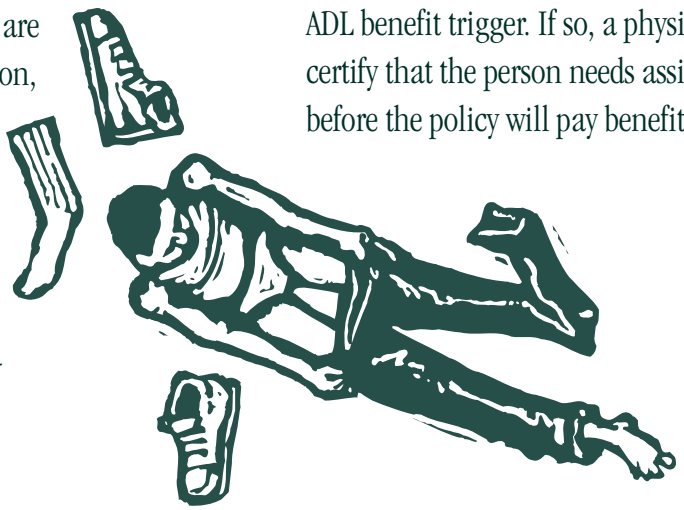
Lump sum: Establishes the total sum of money that can be used for covered LTC services. It usually includes a daily limit.

Policy exclusions

Policy exclusions are identified in a long-term care policy as items that will not be covered by the policy. Policies sold in Washington state are allowed to exclude the following:

- intentionally self-inflicted injuries or conditions resulting from attempted suicide
- nursing care covered by workers compensation
- treatment for chemical dependency, alcoholism, or drug addiction
- benefits provided under any state or federal workers compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law
- benefits provided by Medicare or other governmental programs (excluding Medicaid)
- stays in government facilities, unless the insured person is legally obligated to pay
- services performed by a member of the covered person's immediate family
- services outside the U.S. or its territories
- conditions arising out of war or an act of war (whether declared or undeclared)
- conditions arising out of participation in the commission of a felony, riot or insurrection
- services for which there is no charge in the absence of insurance
- experimental treatments, supplies or services
- rest cures and routine physical examinations

In addition, most LTC policies are *not* designed to cover hospitalization, doctor visits, clinic outpatient services, prescription drugs, dental or vision care or supplies, or continence care products. Medicare or other medical insurance may pay for these services.



Benefit triggers

Terms and conditions that must be met before the policyholder begins to receive policy benefits are called *benefit triggers*. They define the type and degree of impairment that must be present before the policy begins to pay.

Only three benefit triggers are currently allowed in Washington state:

1. inability to perform three of six ADLs

2. physician's certification

3. cognitive impairment

NOTE: federally "qualified" plans that provide for special tax treatment under the 1996 Health Insurance Portability and Accountability Act may contain other triggers; see p. 28 for more information.

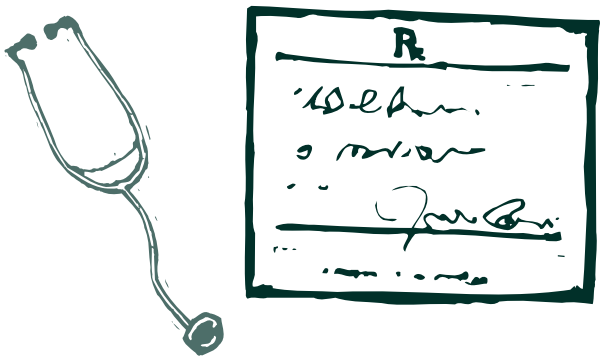
One or more of these three allowed benefit triggers can be found in most LTC policies. Following is background on them.

1. ADLS (ACTIVITIES OF DAILY LIVING)

A policy states *how many* ADLs must "fail" (require assistance) to trigger benefits. In Washington, no policy may require that more than three of six ADLs fail in order to trigger benefits.

A policy may specify whether standby or hands-on assistance is needed to perform ADLs. A policy requiring that a person need hands-on assistance before it will pay benefits is much stricter, since the patient must be more debilitated for benefits to begin.

Who must certify need for care may be part of the ADL benefit trigger. If so, a physician may have to certify that the person needs assistance with ADLs before the policy will pay benefits.



2. PHYSICIAN CERTIFICATION

If a policy has a physician's certification benefit trigger, then a physician must certify that the *level of care* being received is *necessary and appropriate.*

In the past, most insurance companies required that a doctor authorize or prescribe all long-term care services. However, it is now becoming common for insurers to specify that the long-term care plan of care must be approved by a "case manager."

Case managers (also called care coordinators or care advisors) assess needs and coordinate services. They evaluate medical, social, and family situations to determine the most appropriate type and location of care. Case managers may work with physicians to develop a treatment plan.

The case manager might work for an Area Agency on Aging or government organization, be an employee of an insurance company or home health care agency, or act as an independent private consultant.

Which type of case manager is required for certification should be considered when evaluating a policy.

Note:

If you intend to receive care in a nursing facility, a policy that pays only after failure of three ADLs (the state-regulated maximum) is sufficient. But you are more likely to collect home care benefits if your policy requires only two ADLs to fail before benefits are paid. By the time three ADLs have failed, a patient usually requires care in a facility.

3. COGNITIVE IMPAIRMENT

Cognitive impairment is commonly described as deterioration or loss of intellectual capacity, as shown by measurable deficits in the areas of memory, orientation, and reasoning. Alzheimer's disease and similar forms of dementia are conditions that can produce these deficits.

State regulations stipulate that if a person requires verbal cueing, he or she meets the definition for cognitive impariment.

Other policy limitations/ restrictions

After benefit triggers have been satisfied so that your policy begins to pay a claim, the policy's specific benefits become available to you. But even after coverage "kicks in" and a policy begins to pay benefits, there can be further limitations on those benefits.

Additional stipulations may specify who and what decides whether benefits are payable, as well as when and where benefits are payable. Such restrictions can also be found in *"if"* statements in the policy (e.g., "care will be covered IF..."). These are sometimes called *gatekeepers.*

Virtually all long-term care policies have these provisions. They help the company to limit the number of eligible claims, manage their risks and control losses. Therefore, the more restrictive the number and/or nature of policy's gatekeepers, the cheaper the policy.

(Of course, if needed benefits are denied because the situation does not satisfy a policy's strict gatekeepers, it can turn out to be costly in the end. That's why it's crucial to understand how to identify and interpret these restrictions in a policy.)

e.g. Gatekeepers

● One example of a gatekeeper is a restriction on *where* care is received and from *whom*. Benefits can be denied unless you receive care from a particular location and/or specified personnel. If the types of providers specified in the policy are not available in a claimant's geographic area, the benefit may be unusable.

● Provider licensing and certification may also be gatekeepers. For example, to be eligible for payment, nursing homes must be licensed by the Department of Social and Health Services (DSHS). Adult residential care must be licensed as "boarding homes" by DSHS. Home health agencies must be licensed.

● Some policies require enrollees to use participating providers/facilities (with which they contract). If you don't use the participating facilities or providers, there may be reduced benefits or the company may deny the claim.

Important definitions

Below are explanations of key terms you may see in policies, comparison forms, and the disclosure information that is delivered with policies. These describe aspects of benefits and requirements that set policies apart from one another, and which could make a policy appropriate or inappropriate for you.

Alternative plan of care

Alternative care refers to care or services not specified in a policy that may be provided in lieu of normal contract benefits (if appropriate and agreed upon by the insurance company, the insured person, and his or her physician). For example, the insured may choose an adult family home instead of a nursing home, or structural changes to a home such as ramps or hand rails.

Some long-term care policies require an "alternative plan of care"—a written designation of what will be provided, who will provide it and for how long—in order for alternative care to be covered. Policies may further specify that this plan must be written or certified by a specific person, such as a physician or case manager.

NOTE: In some policies, alternative care is part of the base policy, while in others, it is only covered if you buy a version that includes home care benefits. Make sure your policy allows for alternative care even if you choose not to buy home/community-based levels of care.

NOTE: For alternative care benefits to be paid, some policies only require that without alternative care, you *would* be in a nursing facility or eligible for policy benefits. Others allow alternative care only *after* you're *already* in a facility. Again, be sure your policy is not more restrictive than you may need.

Bed reservation

This pays to reserve the nursing home bed space left temporarily by the policyholder if he needs to go into the hospital, usually up to a designated maximum number of days.

Elimination period

A policy elimination period is the amount of time that needs to pass, after the individual begins receiving a long-term care service, before the policy begins to pay (somewhat like a deductible).

The most common elimination periods (though there are others) are:

- Zero days (payment starts on the first day of nursing home confinement);
- 20 days (payment starts on the 21st day of confinement)
- 100 days (payment starts on the 101st day of confinement)

The policyholder pays the cost of the first 20 or 100 days (or however many days the elimination period specifies).

This spares the insurance company the coverage expense for this initial period of confinement; hence, the premium can be reduced. Generally, the longer the elimination period, the lower the premium.

Elimination Period

e.g.

EXAMPLE: A policy with a 100-day elimination period would require you to pay out of your own pocket for the first 100 days of confinement. If the cost of care was $100 per day, this expense would total $10,000. A 20-day elimination period would reduce the out-of-pocket payment to $2,000 ($100 x 20 days).

Guaranteed renewable

In Washington state, no insurer can refuse to renew any long-term care contract or coverage issues after January 1, 1988, except for nonpayment of premium.

Inflation Protection

This option increases your policy's benefit amount periodically. While it's unlikely to *fully* cover inevitable cost increases over the life of a policy, it can cushion the impact significantly.

Inflation riders commonly increase the daily benefit by 5 percent per year, up to a cumulative maximum increase (say 50 percent).If you choose a *simple* inflation option, the daily benefit will annually increase by a fixed 5% of the *starting* daily benefit amount. With a compound inflation option, the daily benefit increases to 5% of the *previous year's* daily benefit.

See the difference:

Year	No Protection	5% Simple	5% Compound
1	$100	$105	$105
2	$100	$110	$110.25
3	$100	$115	$115.76
4	$100	$120	$121.55
5	$100	$125	$127.63
10	$100	$150	$162.89
15	$100	$175	$207.89
20	$100	$200	$265.33

With simple or compound increases, your initial premium is higher than without inflation protection, but remains fixed over the life of the policy. (Your total increased payout may be 30 to 50 percent over the life of a policy, however.)

Yet another alternative is the *indexed* method, which offers the chance to buy more coverage at predetermined intervals, with a corresponding increase in premium each time coverage is increased.

Whether a policy will keep pace with inflation is a serious concern. An inflation rate of seven percent can double the price of services in 10 years. Washington State Medicaid payments to nursing homes show an average increase of 10 percent per year since 1987.

Some planners recommend that those buying a policy under age 70 consider the compound inflation option, while those over age 70 can forego inflation protection if they purchase an adequate daily benefit amount.

Level premiums at age of entry

Policies with this benefit will consider you to be the age at which you purchase your policy for the life of the policy. For example, if you purchase the policy at age 65, for all intents and purposes you would be treated as age 65 for the life of the policy. Any class rate increases would be based on you being 65 years old, even 10 or 15 years after purchase.

Nonforfeiture benefit

Some people who buy LTC insurance are unable to continue paying premiums due to changed circumstances. A nonforfeiture benefit keeps you from forfeiting all benefits should you drop the coverage. A policy with this feature continues to provide reduced benefits (the duration depends on the policy) even after you stop paying premiums, in compensation for the money already paid in. The feature may be usable only if after a policy-specified number of years of paying premiums.

Post-claim underwriting

Some companies will sell a policy without underwriting (evaluating the health of the insured and assessing pre-existing conditions that might lead to a claim) at the time of sale. They only investigate pre-existing conditions if a claim is filed within the first two years after purchase of a policy (the contestability period, or time during which a claim may be challenged).

It requires less work and resources for a company to simply start receiving premiums without performing underwriting investigations when the policy is first sold. But you may be paying premiums for a policy that can deny you benefits when you need them the most.

Prior Hospital Stay

LTC policies sold after December 31, 1987 *cannot* require a prior hospitalization as a condition of coverage. However, some older policies may require a prior hospital stay before benefits will be paid.

In the past, policyholders were sometimes assured by insurance salespeople that a doctor would put them in a hospital long enough to satisfy policy requirements, or that they could pay for a hospital stay themselves. However, physicians will *not* do this.

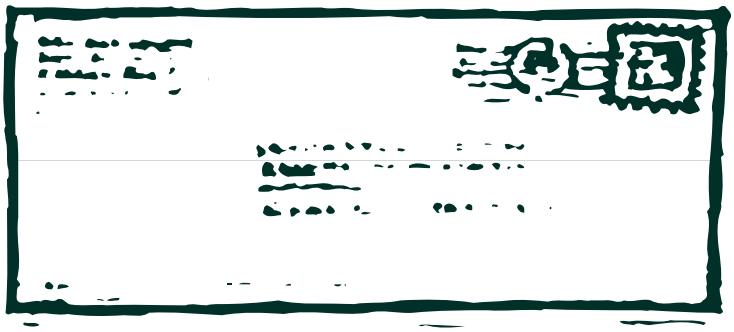
Neither is it possible for insured people to admit themselves to a hospital for the required number of days in order to satisfy this gatekeeper. If a policy requires prior hospitalization, the days in the hospital must be "medically necessary."

It is increasingly difficult to fulfill a prior hospital requirement due to changes in Medicare, and because much care is now provided on an outpatient basis. Often an individual goes directly into a nursing home or receives home health care benefits without a prior hospital stay. An Alzheimer's patient, for example, usually does not require hospitalization before long-term care services are necessary.

Therefore, people with older policies stipulating a prior hospital requirement may want to consider replacing the policy. You may also check to see if the carrier will let you eliminate the requirement on the existing policy by paying an additional premium.

Reduction of coverage

In Washington, people who have purchased long-term care insurance have the right to reduce the benefits of the policy or contract without providing evidence of insurability (i.e., without undergoing underwriting as if they were purchasing a new policy). The policyholder can make changes such as a longer elimination period, a lower daily benefit, or a shorter benefit period (assuming the insurer offers policies with these lesser benefits), resulting in a smaller premium.



Reinstatement

Long-term care insurance policyholders in Washington state have the right to reinstate coverage after a lapse or termination due to nonpayment of premiums, if the insurer is provided proof of the insured's cognitive impairment or loss of functional capacity, and if reinstatement is requested within five months after the policy lapsed or terminated.

(The required proof of cognitive impairment or loss of functional capacity cannot be any more stringent for resinstatement than it is for benefit eligibility.)

Restoration of benefits

If you receive benefits, then later get well and don't enter a new claim period (make any more claims) for a specified amount of time, the benefits you used may be restored—that is, they become once again available, not counted as used.

Return of premium

A return of premium refers to the refund of all premiums paid minus any benefits/claims paid during the life of the policy, in the event of a lapse in the policy due to nonpayment of premiums. A return of premium is not allowed in Washington state for long-term care insurance (or any other insurance except for disability insurance). However, policies purchased in other states may have this benefit.

Spell of Illness

A Spell of Illness (SOI) is also known as "one period of confinement" in the Washington regulation. It defines the time that will be allowed between the end of one period of medical treatment and the start of another, in order for the more recent instance to be covered without having to satisfy a new elimination period or deductible period.

A point to clarify is whether the SOI remains in effect if care is needed within the specified time frame, *but for a different condition*. If your policy specifies a 180-day SOI, and you leave the nursing home after care for a broken hip but have to return because you have a stroke, would you still be covered as long as you returned within 180 days? Or would you have to start a new elimination period before benefits would be paid?

Usually, the newer (current) period of treatment must be for the same or related illness or injury as the previous one. Refer to the policy.

CASE STUDY:

A 180-DAY SPELL OF ILLNESS

Mr. Jones has a LTC policy with a 180-day SOI and a 20-day elimination period before daily benefits start to be paid. He has been in a nursing home for 100 days. Now he's left to go home. After 120 days at home, Mr. Jones has a relapse and needs to go back to the nursing home. Because his relapse occurred before 180 days was up, he can return to the nursing home and "pick up where he left off." The 20-day elimination period was already satisfied for this "period of confinement." His first day back at the nursing home would be counted as the 101st day of his stay as if no time has passed.

If his relapse had occurred *more* than 180 days after his discharge, Mr. Jones would be "starting over." He would pay out of his own pocket for the first 20 days in the nursing home (since his policy's elimination period is 20 days). The policy would start to pay again on the 21st day.

Spousal discounts

There are policies with premium discounts if both spouses purchase coverage from the same company (usually, the same coverage at the same time). Some companies sell a single policy covering both spouses.

There are policies that will eliminate the premium for the living spouse if the other spouse dies, if both had a policy for a certain number of years.

Third party notice of lapse

All policies must permit the insured to designate at least one additional person to receive notice of lapse or termination for nonpayment of premium, in case the premium is not paid by its due date, and the coverage cannot lapse until at least 30 days after the notice is mailed to the third-party designee (60 days for insureds paying a premium through a payroll or pension deduction plan). This protects the policyholder from lapse or termination in case cognitive impairment or loss of functional capacity results in nonpayment of premiums.

Waiver of premium

A waiver of premium allows you to stop paying premiums after a designated time following the start of policy-covered care.

Some policies will waive premiums after a certain number of "days in facility." Others will waive premiums after a certain number of "covered benefit days."

If a policyholder has a 90-day waiver of premium, after the first 90 days of covered care he will no longer have to pay policy premiums. (If the policy also has a 20-day elimination period, however, it will be 110 days before policy premiums no longer need to be paid. For more on elimination periods, see pp.22-23.)

GROUP LTC

A regular individual insurance policy is a contract directly between an insurance company and you, the insured person. With group insurance, an insurance company issues a policy to a group (employer, labor union, or professional/trade/occupational association), which is legally the "policyholder." As a covered member of the group, you are an "insured" (sometimes called certificate holder).

If you're insured under a group policy, you don't have a policy directly with the insurance company. You have a certificate of coverage that explains your benefits, rights, and obligations.

Washington state law requires all individual policies delivered in the state to conform to its requirements. With group insurance, the type of group and the state in which the master policy holder is located determine to what extent Washington state requirements and protections apply.

When a policy is issued to a group located in Washington state, all LTC requirements must be met, and Washington insurance regulations protecting the consumer apply regardless of the location of the insurance company.

However, if the group is located in another state, then it is called an "out-of-state group" and consumer-protective Washington requirements may or may not apply.

Also, an individual LTC policy must be issued on a "guaranteed renewable" basis. (Your policy cannot be cancelled except for nonpayment of premiums, and the insurer cannot change any provision of the policy without your consent.)

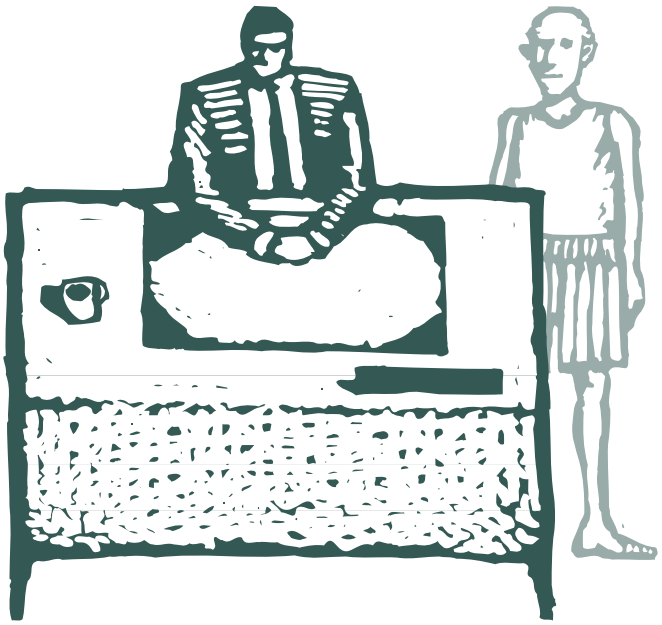
But group policies are not usually issued on a guaranteed renewable basis (though they are guaranteed *continuable*, meaning the insurance company reserves the right to cancel the contract, but not the individual coverage). With group insurance, the company also reserves the right to change premiums and policy benefits.

Group policies issued in Washington are required to provide a continuity of coverage (no break in coverage) for the insured (certificate holder). That means if group coverage ends, the company must make some sort of arrangement to take care of the insureds. You might be permitted to purchase individual coverage at different rates, or to continue the group benefits by paying the premium directly to the insurance company.

Many large companies "self insure" and use a division of an insurance company to administer their plans. *Self-insured programs need not comply with current Washington regulations.*

Group insurers who do not agree to comply with selected Washington benefit requirements cannot sell their insurance in Washington state.

An agent cannot legally solicit Washington consumers to purchase policies that do not meet Washington requirements.



Public Employees Benefits Board

Few states or other employers offer long-term care insurance to their employees, but Washington state does. Legislation passed in 1996 directed the state's Public Employees Benefits Board (PEBB) to make a voluntary long-term care insurance plan available to eligible state employees, retired state employees, retired public school employees, and eligible dependents (spouses, children, parents and in-laws of the employee/retiree).

Parents do not have to live in Washington state to be eligible for a PEBB long-term care policy. They will be able to enroll independent of whether the employee participates, and may pay premiums independently. The employee or retiree may also make arrangements to pay the premiums for their parents or other dependents.

For information on the PEBB long-term care plans, call (800) 399-7271, or consult a SHIBA HelpLine volunteer (see the front and back of this guide for more info).

Federal Changes Affecting LTC Insurance in Washington State

On January 1, 1997, the Health Insurance Portability and Accountability Act (HIPAA) went into effect. This act covers a range of health insurance issues, including long-term care.

Often called the Kassebaum-Kennedy bill, this act gave certain long-term care expenses a tax-exempt or favored status, when *qualified* plans are used to cover care.

What qualifies a plan for special tax treatment?

Specific benefit triggers qualify a LTC plan for the favorable tax treatment under HIPAA:

- Certification by a licensed health care practitioner that patient is unable to perform (without substantial assistance from another individual) at least two activities of daily living, for a period of at least 90 days, due to a loss of functional capacity.

NOTE: This does *not* mean that a 90-day elimination period is required in the contract. It means that an anticipated 90-day period of loss of function must be certified.

- Certification by a licensed health care practitioner that patient requires "substantial supervision" for protection from threats to health and safety, due to severe cognitive impairment.

NOTE: These benefit triggers would replace those allowed in Washington state for regular, non-qualified plans. *(See chart below.)* They may be stricter than Washington state standards expressly created to make LTC products usable in a greater variety of situations.

Tip:

Before choosing a qualified plan over a non-qualified plan, it's a good idea to calculate how much you could actually save. Is the savings worth potential lost value due to the stricter, more limiting benefit triggers of qualified plans?

For many people, the deduction may not amount to much. Premiums are deductible as a medical expense for those who *itemize.* A person with an adjusted gross income of $30,000 who bought a long-term care policy for $1,400 (average price for a person in his mid-60s) would need another $950 of medical expenses before he could get even a $100 deduction.

The stricter federal standards, while qualifying a plan for special tax treatment, may make it easier for insurance companies to deny claims.

Thus it is important to weigh preferred tax treatment against product usability/flexibility.

BENEFIT TRIGGERS COMPARISON

Qualified Plans

- Certification by a licensed health care practitioner that patient is unable to perform (without substantial assistance from another individual) at least two activities of daily living, for a period of at least 90 days, due to a loss of functional capacity. (NOTE: This does *not* mean that a 90-day elimination period is required in the contract. It means that an anticipated 90-day period of loss of function must be certified.)
- Certification by a licensed health care practitioner that patient requires "substantial supervision" for protection from threats to health and safety, due to severe cognitive impairment.

Non-Qualified Plans

- inability to perform three of six ADLs
- physician's certification that the *level of care* being received is *necessary and appropriate.*
- cognitive impairment (all forms of mental or emotional)

Qualified services

Qualified long-term care *services* under the law include necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, and maintenance services or personal care.

If the federal requirements are met to qualify a plan and/or services, the special tax treatment is as follows:

- Premiums for *qualified* insurance will be deductible as medical expenses (for those who qualify for medical deductions).
- Benefits from qualified long-term care (LTC) insurance will not be taxed/treated as income (subject to a cap of $175 per day or $63,875 annually on indemnity contracts).
- LTC expenses not covered by insurance will be deductible as medical expenses (up to certain limits) *for those who itemize.*
- Employer-paid premiums of LTC insurance will not be treated as income.
- Tax-qualified policies must coordinate with Medicare (i.e., if Medicare pays, the policy doesn't have to pay).
- A nonforfeiture benefits *option* must be available in all policies (i.e., it is mandatory that the *option* is *offered;* this does not mean the benefit will be included as standard feature in all policies).
- Premiums paid by employers are deductible for the employer as a business expense.

Policies that were sold up until January 1, 1997 that meet state standards will be grandfathered (considered qualified).

This is a federal act, and states are waiting to hear from the Treasury regarding interpretation of sections of the law. For late-breaking information, consult a SHIBA volunteer. Also, it is a good idea to consult with a tax advisor before buying such a policy.

Effective Dates

The federal law affects qualified policies issued beginning January 1, 1997.

Policies that were issued before January 1, 1997, and which meet state standards, will be grandfathered (be considered qualified), meaning insureds will not have to exchange these policies for new ones to get the tax relief. These older policies will retain their original benefits and features (even if their benefit triggers differ from those required for newer plans in order to qualify).

Non-qualified policies issued between January 1, 1997 and December 31, 1997 may be exchanged for qualified policies, if the policyholder wants to exchange product usability for tax breaks.

Note:

The person purchasing the policy is the recipient of the tax deductions. If an individual purchases the policy for a parent, the buyer (child), not the insured (parent), can deduct the premiums from his or her taxes.

When you have insurance already

If you're uncertain about your current policy

It's much better to understand the benefits and limitations of a policy before buying. However, Washington state law gives consumers a 30-day "free look" period on long-term care policies (60 days if purchased by mail).

If you have already purchased a policy and are uncertain about it, use this guide's advice, and if needed the help of a SHIBA volunteer, to assess whether (1) you are a good candidate for LTC insurance, and (2) whether you have the right policy for you.

If the policy you have purchased does indeed appear to be the wrong choice, you can can receive a full refund if you are in the free look period. This process would be initiated by sending a letter requesting cancellation, certified mail (return receipt requested) to the insurance company.

If you're past the free look, other options may include:

- ☑ upgrading the policy
- ☑ replacing the policy with a different one, or
- ☑ cancelling the policy (a portion of the premiums may be refunded; check policy benefits).

You should be sure it is really worth it to cancel the policy, given what it might cost to get a new one, and what might be lost in terms of premiums already paid in.

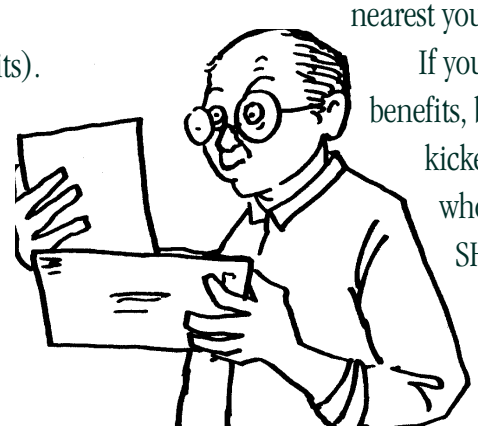
Sorting out these options will involve studying the existing policy and its benefits, contacting the agent who sold the policy if possible, and working to assess LTC risks, needs, and financial status as covered earlier in this guide.

If you feel a claim has been unfairly denied

First contact the insurance company or legal representative to find out the exact reason given for the denial.

If the denial is for a medical reason—which is frequently the case—contact the doctor in charge of your care (or the insured's care). Sometimes a doctor's office sends unnecessary or incorrect information, to the insurance company that provides a basis for denying the claim.

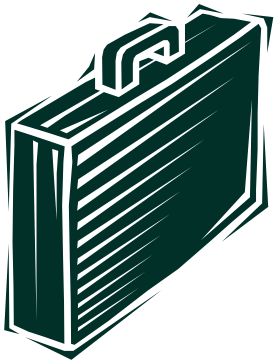
If misinformation has been corrected and the company still denies the claim, or if the reason given is not a legitimate one according to Washington state law, contact SHIBA HelpLine for advocacy. Call (800) 397-4422 for the number of the SHIBA volunteer nearest you.



If you have a policy and need benefits, but triggers have not kicked in, contact the agent who sold the policy or a SHIBA HelpLine volunteer.

Your physician may be contacted to determine the reason for the discrepancy, if a physician certification trigger is the issue (i.e., physician does not certify that care is necessary and appropriate, or physician does not certify that ADLs have failed).

In addition, the grievance procedures specified in the policy should be followed.



What should you have handy when making decisions or getting counsel?

Whether representing yourself or as a guardian/representative for a family member or loved one, *ideally* you should be prepared with everything pertaining to the *total financial picture* that cannot be determined from memory. This may include all bills payable monthly, all income information (Social Security, pension, employment), savings and other liquid assets, investments, amount of home equity, and other assets.

In reality, this will not be feasible for some people. However, it is extremely helpful, and the client should be encouraged to provide as much as he possibly can.

Unsavory practices

It can be difficult for state insurance commissioners to regulate insurance policies that were delivered in another state but sold in their own through telemarketing, national advertising or direct mail marketing.

In Washington state, statutes regulating marketing practices are used to ban deceptive advertising or unfair practices, without directly regulating policies or companies.

Report suspicious activity in long-term care marketing, sales or service to the Office of the Insurance Commissioner Consumer hotline (800-562-6900).

Problems to watch for include:

- The selling of annuities to get "free" long-term care insurance.
- Selling life insurance as if its accelerated benefits were long-term care insurance.
- General advertising and sales practices that are either inciting fear or misrepresenting products.
- Misleading "trust seminars" that misrepresent Medicaid laws.
- Very aggressive salespeople wanting you to buy on the spot.

POLICY EVALUATION WORKSHEETS

What levels of care are covered by the policy?	POLICY 1	POLICY 2	POLICY 3
DOES THE POLICY PROVIDE BENEFITS FOR THESE LEVELS OF CARE:			
Nursing care (skilled)			
Personal care *Note: Some policies may still refer to this as "custodial care" even though the term is considered obsolete and is not used by government agencies.*			
DOES IT PAY FOR ANY NURSING HOME STAY REGARDLESS OF THE LEVEL OF CARE YOU RECEIVE?			
If not, what levels are excluded?			

Where can you receive care covered under the policy?			
DOES THE POLICY PAY FOR CARE IN ANY LICENSED FACILITY?			
If not, what are the restrictions on where you can obtain care?			
DOES THE POLICY PROVIDE HOME CARE BENEFITS FOR:			
Skilled care			
Care by home-health aides			
Homemaker services			
DOES THE POLICY PAY FOR CARE RECEIVED IN:			
Adult day care centers			
Community centers			
Other settings? (list)			

How long are benefits provided and what amounts are covered?

	POLICY 1	POLICY 2	POLICY 3
WHAT IS THE MAXIMUM DAILY BENEFIT AMOUNT FOR:			
Nursing home care			
Home care			
ARE THERE LIMITS ON THE NUMBER OF DAYS (OR VISITS) PER YEAR FOR WHICH BENEFITS WILL BE PAID?			
If so, what are those limits for:			
Nursing home care			
Home care (days or visits)			
WHAT LENGTH OF BENEFIT PERIOD ARE YOU CONSIDERING?			
ARE THERE LIMITS ON THE AMOUNTS THE POLICY WILL PAY DURING YOUR LIFETIME?			
If so, what are those limits for:			
Nursing home care			
Home care			
Total lifetime limit			

Does the policy have inflation protection?

ARE BENEFITS ADJUSTED FOR INFLATION?			
ARE YOU ALLOWED TO BUY ADDITIONAL INCREMENTS OF COVERAGE?			
If so:			
When can you buy additional coverage?			
How much can you buy?			

	POLICY 1	POLICY 2	POLICY 3
When can you no longer buy additional coverage?			
Are benefits increased automatically?			
If so,			
What is amount of the increase?			
When do automatic increases stop?			
Is this a simple or compound increase?			
IF YOU BUY INFLATION COVERAGE, WHAT DAILY BENEFIT WOULD YOU RECEIVE FOR:			
Nursing care:			
5 years from now			
10 years from now			
Home care:			
5 years from now			
10 years from now			
AFTER LIMITS HAVE BEEN REACHED FOR INFLATION ADJUSTMENTS, WHAT IS THE MAXIMUM BENEFIT YOU WILL RECEIVE FOR:			
Nursing care			
Home care			
What other provisions are covered under the policy?			
A WAIVER OF PREMIUM PROVISION?			
If so, how long do you have to be in a nursing home before it begins?			
A NONFORFEITURE BENEFIT?			
What kind?			

	POLICY 1	POLICY 2	POLICY 3
A RETURN OF PREMIUM BENEFIT?			
A DEATH BENEFIT?			
If so, are there any restrictions before the death benefit is paid?			

When do benefits begin?

HOW LONG IS THE ELIMINATION/WAITING PERIOD BEFORE BENEFITS BEGIN FOR:			
Nursing home care			
Home health care			
HOW LONG WILL IT BE BEFORE YOU ARE COVERED FOR A PRE-EXISTING CONDITION?			
HOW LONG WILL THE COMPANY LOOK BACK IN YOUR MEDICAL HISTORY TO DETERMINE A PRE-EXISTING CONDITION?			

How does the policy determine when you are eligible for benefits?

WHICH BENEFIT TRIGGER(S) DOES THE POLICY USE TO DETERMINE ELIGIBILITY FOR BENEFITS? *(It may have more than one.)*			
Doctor certification			
Medical necessity			
Failure to perform activities of daily living (ADLs)			
Cognitive impairment			
Prior hospital confinement			

	POLICY 1	POLICY 2	POLICY 3
IF THERE IS AN ADL BENEFIT TRIGGER, Are ADLs spelled out clearly?			
Does the policy specify what is meant by failure to perform one?			
IS THERE A SEPARATE TRIGGER FOR QUALIFYING FOR BENEFITS IF YOU HAVE A COGNITIVE IMPAIRMENT (such as Alzheimer's disease)?			
What does the policy cost?			
ANNUAL PREMIUM EXCLUDING ALL RIDERS			
ANNUAL PREMIUM IF HOME CARE IS COVERED			
ANNUAL COST OF INFLATION RIDER			
COST OF NONFORFEITURE BENEFIT			
DISCOUNT IF YOU AND YOUR SPOUSE BOTH BUY POLICIES			
If so:			
What is the amount of the discount?			
Do you lose the discount if one spouse dies?			
TOTAL ANNUAL PREMIUM WITH ALL RIDERS AND DISCOUNTS			

Policy Evaluation Worksheets are adapted in part from the **National Association of Insurance Commissioner's** *Shopper's Guide to Long-Term Care Insurance*

WAYS TO PAY FOR LONG-TERM CARE

	What it is	Possible PLUSES	Possible MINUSES
SELF-PAY *(savings, family money, trusts, annuities, reverse mortgages, other investments)*	If you need long-term care services, you pay for all services 100% out of pocket. This can be done by using cash/ savings, income-producing investments, or other strategies.	If you never do need long-term care, you have paid nothing out of pocket.	If it turns out that you do require long-term care, the expenses could overwhelm you and/or your family and exhaust nearly all resources. Nursing homes can cost $4,000 to $5,000 per month, and home care can be even more costly.
INSURANCE	A private insurance policy may be purchased for protection against possible long-term care expenses. In Washington State, all policies are guaranteed renewable and cover all forms of mental and emotional as well as physical disorders.	If you select the right policy for you, you can protect yourself, your family and your assets against the financial and practical burdens of providing long-term care in the event that you require it. The cost of a policy buys peace of mind, and can be minor compared with potential out-of-pocket costs.	If you never need long-term care, the cost of insurance will have exceeded any out-of-pocket expenses for long-term care.
MEDICAID	A state and federal aid program that may pay all or part of long-term care costs for individuals who are categorically eligible (by reason of financial need based on income and asset levels).	If your income and asset levels are already at or near the qualifying levels, you can get coverage if you need it.	If your income and asset levels are *not* already at or near the qualifying levels, you will have to "spend down" (deplete your assets) to those levels before you can receive assistance.

IF YOU NEED MORE HELP...

SHIBA HELPLINE is an impartial, confidential resource to help you evaluate, choose and use your health insurance.

A statewide network of highly trained volunteers stands ready to educate you on health insurance issues, so you can make informed decisions. Our counselors have up-to-date information on most health insurance concerns. They can answer questions and assist with insurance planning.

Their services are FREE. And they have no affiliation with any insurance company or product.

SHIBA HELPLINE was the first health insurance peer counseling program of its kind in the nation, and is now a model for the rest of the United States.

SHIBA HELPLINE has an office in nearly every Washington State county. Call to get the number of the SHIBA HelpLine sponsor nearest you.

1-800-39-SHIBA
(1-800-397-4422)

RESOURCES

HOTLINES, ORGANIZATIONS

- For consumer brochures about health insurance, and referral to nearest local SHIBA office: SHIBA HelpLine / (800) 397-4422
  http://www.insurance.wa.gov/consumers/shiba/default.asp

- With all other insurance questions/comments/suggestions *(auto, life, homeowner, etc.)* :
  Insurance Commissioner's Consumer Hotline / (800) 562-6900
  www.insurance.wa.gov

- Centers for Medicare and Medicaid Services (CMS)
  Consumer Services (206) 615-2354
  Medicare Hotline (800) 633-4227
  Medicare Managed Care (206) 615-2351
  www.medicare.gov

- Social Security Administration (800) 772-1213
  www.ssa.gov

- National Elder Care Locator Service (800) 677-1116

- Health Care Authority (360) 923-2600
  www.wa.gov/hca

- Public Employees Benefit Board (PEBB) (800) 399-7271

PUBLICATIONS

Centers for Medicare and Medicaid Services (CMS)
www.medicare.gov 1-800-MEDICARE

- *Medicare & You; Guide to Health Insurance for People with Medicare ; Your Medicare Benefits; Medicare and Other Health Benefits: Your Guide to Who Pays First ; Medicare Hospice Benefits; Medicare and Your Mental Health Benefits; Medicare and Home Health Care; Medicare Coverage of Skilled Nursing Facility Care; Your Guide to the Outpatient Prospective Payment System; Women With Medicare; Medicare Savings Programs (see website for more)*

National Association of Insurance Commissioners (NAIC)

- *A Shopper's Guide To Long-Term Care Insurance*
  Publications Dept., 120 West 12th Street, Suite 1100
  Kansas City, MO 64105

TO ORDER CONSUMER PUBLICATIONS FROM THE OFFICE OF THE INSURANCE COMMISSIONER, GO TO www.insurance.wa.gov, OR USE ORDER FORM ON THE OPPOSITE PAGE. ->

PUBLICATIONS ORDER FORM

or order online at www.insurance.wa.gov or http://www.insurance.wa.gov/shibahelpline.htm

PLEASE PRINT NAME, ADDRESS AND TELEPHONE NUMBER.

NAME _____

Street Address _____

City _____ State _____ ZIP _____

Daytime phone number *(in case we have a question about your order)* _____

PLEASE SEND ME ONE EACH OF THE FOLLOWING PUBLICATIONS:

(please check only those you wish to receive)

- ☐ SHIBA HelpLine General Info Brochure
- ☐ Medicare, Medigap & You
- ☐ Medicare Choices
- ☐ Retirement and Your Health Insurance
- ☐ The Consumer's Guide to Financing Long-Term Care
- ☐ Info on options for consumers with disabilities
- ☐ Info on prescription drug coverage
- ☐ Info on individual insurance market/under 65

☐ Please send information on becoming a SHIBA HelpLine volunteer.

☐ I'm interested in having a speaker for my group. Please call me. _____

Name of group _____ Location of group _____

Size of group (audience) _____

Phone number _____ E-mail address_____

See SHIBA HelpLine's website at http://www.insurance.wa.gov/consumers/shiba/default.asp for other helpful consumer brochures, handouts, charts, guides, and fact sheets that can be downloaded or ordered from the site.

FOLD THIS FORM AND PLACE IN ENVELOPE USING ADDRESS BELOW

Office of the Insurance Commissioner
SHIBA HelpLine PUBLICATIONS
810 Third Avenue, Suite 650
Seattle, WA 98104-1615

Office of the Insurance Commissioner
SHIBA (Statewide Health Insurance Benefits Advisors) HelpLine
810 Third Avenue Suite 650
Seattle, WA 98104-1615
1-800-397-4422

Need help with an insurance problem or question? The Insurance Commissioner's Consumer Advocacy division has experts in all lines of insurance (auto, homeowner, life, disability and health) who can assist you. Call our toll-free hot line at 1-800-562-6900.

In addition, if you need help with health insurance issues, Statewide Health Insurance Benefits Advisors (SHIBA) HelpLine is a free service of the Insurance Commissioner's office. SHIBA HelpLine provides specialized health insurance education, assistance, and advocacy, including individualized counseling regarding your rights and options. Call 1-800-397-4422 to be referred locally for assistance.

Consumer's Guide to Financing LTC

is part of the consumer guide series published by The Office of the Insurance Commissioner

SEE ALSO:

- Medicare, Medigap & You
- Retirement and Your Health Insurance
- Medicare Choices
- Health Insurance Options for People with Disabilities
- Health Insurance Options in the Individual Market
- Paying for Prescription Drugs
- Navigating Health Care

PRINTED ON RECYCLED PAPER

SHP600FR 3-03

THIS PUBLICATION MADE POSSIBLE BY STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP) GRANT FUND GRANT FUNDS FROM THE U.S. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)